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Life on the Edge: Immigrants Confront the American Health System

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Abstract

On the basis of a study of forty health care delivery institutions in Florida, California, and New Jersey, this paper examines the interaction the immigration and health systems in the USA. We investigate barriers to care encountered by the foreign-born, especially unauthorized immigrants, and the systemic contradictions between demand for their labor and the absence of an effective immigration policy. Lack of access and high costs have forced the uninsured poor into a series of coping strategies, which we describe in relation to commercial medicine. We highlight regional differences and the importance of local politics and history in shaping health care alternatives for the foreign-born.

Keywords

Unauthorized immigration; health insurance; language assimilation; transnationalism; institutionalized compassion; free clinics

Introduction

Over the last half century, immigration has transformed America's demographic profile. By 2008, the foreign-born had surpassed 40 million and represented approximately one in seven of all residents in the country. Immigrants and their children numbered 70 million or almost 1-in-4 persons. New ethnic groups – Hispanics and Asian-Americans – that did not exist officially fifty years ago now represent today the fastest growing component of the U.S. population. Forty million Hispanics alone have become the nation's largest ethnic minority (Rumbaut 1997; Portes and Rumbaut 2006: Ch. 2; Rumbaut 2007; Passel, 2009).

In this paper we examine the interaction between the present wave of immigration and the American health system. We begin by noting a key aspect of contemporary immigration: far from being a homogenous flow, it is bifurcated. One current comprises high human capital migrants who fill professional and technical positions. This flow has been greatly aided by the creation of the H1-B program for temporary professional workers by the U.S. Congress in 1990. Professional and technical migrants arrive with legal status, receive salaries commensurate with their skills, and are generally insured. Overwhelmingly, they come from large Asian countries – China, India, and the Philippines – and, secondarily, from Canada and South America (Office of Immigration Statistics 2008; Portes and Rumbaut 2006: 24-28).

At the other end, the need for manual labor in sectors like agriculture, construction, low-tech industry and services is filled by an underground flow. In the absence of a legal temporary labor program, peasants and workers from Mexico, Central America, and the Caribbean

cross the border surreptitiously or overstay their tourist visas. They do so attracted by U.S. wages which, in the case of Mexico, stand at a 7-to-1 relation. (Massey *et. al.* 2002; Cornelius 2001). An estimated 11.1 million unauthorized persons reside in the U.S.A.

Sooner or later, migrants confront the American medical institutions, which are both costly and geared to a population able to pay for services, either directly or through third-party insurers (Guendelman *et. al.* 2001; Mechanic 2006). Professional migrants are generally eligible for health insurance; refugees are covered under various federally-sponsored resettlement programs. Manual labor migrants, even if legally in the country, tend to be uninsured or underinsured.

By fits and starts, the federal and state governments have built a safety net for the health-disadvantaged population, including the homeless and the unemployed (see Light, this issue) - which is largely restricted to persons legally residing in the country. Unauthorized migrants and, since 1996, recent legal migrants are ineligible for Medicaid and other federally-sponsored programs. Some states and counties have similar prohibitions. The health reform bill approved by Congress in 2010 has, as one of its signal characteristics, the exclusion of non-citizens and non-legal residents from coverage. The end result is to confine the unauthorized and poor migrants to the bottom of the health hierarchy, confirming their caste-like status.

The original focus of this study -- to examine the interaction between current immigration system and American health care institutions – devolved almost immediately, into an analysis of the situation confronted by unauthorized foreign workers and their families because they represent the true crisis point in the encounter between the two systems. It is not common to find migrants dying in the streets, suggesting that some other paths to medical attention must exist, despite many existing obstacles. The research question may thus be rephrased as follows: What are these less-than-apparent paths, how do they function, and with what consequences for the labor migrant population?

Research Design

The units of analysis for this study are not individuals but institutions, in particular hospitals and clinics. We interviewed managers, founders, and administrators of such units as well as direct caregivers, such as nurses and physicians. These data were supplemented with interviews with leaders and activists of immigrant organizations and, on several occasions, focus groups of patients. Direct observations of waiting rooms and other public areas completed each institutional study. Forty health-care units were studied in three locations: the Miami-Ft. Lauderdale metropolitan area in South Florida; the San Diego metropolitan area in Southern California; and Central New Jersey, including the Newark-to-Trenton corridor. These areas were selected because of their different “mix” of immigrant groups and also because of their different socio-political contexts which could affect the access to health care and the quality of services.

Miami is the paradigmatic immigrant city. More than half of the city’s population is foreign-born. According to the 2000 census, the total immigrant population in the metropolitan area was 1.56 million or 40 percent of the total. The region is characterized by the political power attained by several foreign groups, in particular Cuban-Americans. (Stepick *et. al.* 2003). Today, Miami-Dade County is not only populated by immigrants but also ruled by them, as most mayors and other elected officials are first or second generation Cuban or Latinos. We expected this political configuration to influence the health delivery system insofar as authorities, who are themselves migrants or children of migrants, may display greater sympathy toward the needs of fellow foreigners.

San Diego is also a high immigration area. Its location on the border to Mexico largely determines the mix of nationalities in the region. While in Miami-Ft. Lauderdale the foreign-born population is mostly of Caribbean and South American origin, in San Diego, Mexicans dominate, followed by smaller concentrations of Central Americans and Asian such as Filipinos, Chinese, and Koreans. In 2000, the foreign-born population was estimated at 606,000 or 21.5 percent of residents in the metropolitan area. By contrast to Miami, immigrants are almost entirely absent from positions of political authority. Instead, San Diego County is governed by a Board of Supervisors, dominated by members of the native business elite who have turned opposition to unauthorized immigration into a crusade, including denial of education and health services to persons without legal status (Weeks and Eisenberg 2007; Connaughton 2007).

Central New Jersey was selected because of the relative recency and unique composition of its immigrant population. By comparison to Miami and San Diego, this is not a gateway city, but a core region with a diversified economic base. During the last two decades, New Jersey has received two flows representative of the polarized character of contemporary immigration: The first encompasses large numbers of H1-B and other professionals employed in pharmaceutical laboratories and other high-tech corporate campuses in the Trenton-Newark corridor; the second comprises an even larger influx of manual labor workers, mostly undocumented, who have settled in the decaying urban areas of Trenton and New Brunswick (LALDEF 2008).

As in San Diego, no particular group dominates the political structure but, in contrast to San Diego, New Jersey has a tradition of strong labor unions and relatively progressive government that affect health care. The state's Charity Care program supplements Medicaid and Medicare and is available to anyone regardless of legal status. In addition, New Jersey is home to strong medical institutions with a community service orientation. This is the case, for example, of the Robert Wood Johnson hospital system and the Catholic-affiliated hospitals, such as St. Francis in Trenton and St. Peter's in New Brunswick.

Table 1 presents a breakdown of the health care institutions studied in the three regions. In addition to them, we found in each area a dense network of private and publicly-funded organizations dealing with specialized medical needs. While these organizations seldom provide direct medical attention, their leaders are valuable informants about the overall health situation in their area and, in particular, the conditions surrounding immigrants and their chances of obtaining suitable care. We use this information to supplement and modify, when needed, the data and points of view supplied by medical administrators, managers, and other personnel of institutions included in the project.

Findings

a. Survey Results

The New Immigrant Survey (NIS) is a nationally representative database of recent immigrants collected by a consortium of universities and housed at the Office of Population Research of Princeton University. It includes a detailed battery of questions on medical symptoms, hospitalization, and insurance. The following results come from the baseline survey, conducted in 2003. Table 2 shows that, overall, immigrants form a healthy population. From a set of 14 indicators of medical conditions, 95 percent of the sample reported "none". The mean is a summated index of medical problems from 0 (no symptoms) to 14. It is close to zero for both sexes and only rises to 1.33 for individuals 64 and older. There is little variation among the principal nationalities represented in the sample although, for Mexicans, the mean of reported conditions is significantly higher.

Similar results are apparent in answer to a question about hospitalization in the preceding year: 94 percent answered negatively. As reported in Table 3, women were less likely to be hospitalized and older migrants slightly more. Among nationalities, the highest rate of illnesses or conditions requiring hospitalization was reported among Mexicans and the lowest by immigrants from Ethiopia. Two caveats apply to these results. First, these are mostly recently arrived immigrants. A body of evidence shows a trend toward worsening health conditions with length of residence in the United States, as migrants acculturate and their physical activity and eating habits change (Rumbaut 1997; Viruell Fuentes 2007; Guarnaccia, this volume). Second, these are legal immigrants. Although some may be formerly unauthorized, they have educational levels and socio-economic characteristics superior to the undocumented population as a whole.

Remarkable is the lack of health insurance in this sample. Despite their legal status, only one-third (32.6%) are covered. There are significant variations among nationalities. Least likely to be insured are migrants from Ethiopia, Poland, and Vietnam. Mexicans, by far the largest group, are also below the sample average. Most likely to be insured are migrants with higher levels of education and employment, such as Indians and Filipinos. Still neither nationality approaches the average health care coverage of the native-born, 87.8 percent. From these results we conclude that, although recent legal migrants are a healthy population, their widespread lack of health insurance augurs ill for the future, especially if the trend toward deteriorating health conditions accompanying acculturation continues (Rumbaut 1995; Portes and Rumbaut 2006).

b. Barriers to Health Care

1. Lack of information—Locations, range of services, and accessibility of facilities, are often unknown to the migrant population. Free clinics and family clinics attached to hospitals do not generally advertise their services; they depend on word of mouth. This is in contrast to the emergency rooms of large hospitals, which are known to most. As a result, ERs become overloaded, often treating serious but non-emergency cases, while services in nearby clinics nearby are under-utilized. Immigrants' ignorance about where to go for care has prompted several clinics to take proactive measures. Open Door Clinic in Homestead, Florida has been known to send its staff into the surrounding agricultural fields to inform migrant workers of the availability of free care. In San Diego, several religiously-affiliated and federally qualified clinics have purchased mobile vans to go into poor migrant areas and make basic medical services available.

2. Cultural/Linguistic Barriers—Lack of English fluency and cultural differences can create impassable barriers. We learned of terrible cases, such as that of an adolescent girl suffering from stomach pains who was taken to the emergency room where neither she nor her parents could properly explain her symptoms in English. The attending doctor gave her some pills and sent her home where she promptly died of appendicitis. By law, hospitals and community clinics must provide medical translation but interactions at the ground level are unpredictable. "Medical translation" may range from clinicians fully bilingual and conversant with the culture of the patients to institutions that depend on the ATT Translation Service or, in a pinch, an orderly or a security guard who happens to speak the language.

Using untrained translators in medical interviews is illegal, but not uncommon in smaller institutions. Using the ATT system is legal, but sufficient. Translation via speakerphone misses multiple details and nuances of body language. As explained by a chief clinician at St. Peter's Hospital in New Brunswick, doctors not only have trouble diagnosing a patient under these circumstances, but have even greater difficulty providing instructions and impressing upon patients the need to follow them.

Cultural/linguistic barriers disappear when a significant proportion of the medical personnel are fluent in the language, and familiar with the culture, of patients. This is often the case in community clinics such as Borinquen in Miami or San Ysidro Medical Center in San Diego. By contrast, in larger hospitals patients often have to wait for hours for the arrival of a qualified translator or must make do with the ATT system.

3. Fear—First is fear of detection and deportation. Migrants often avoid clinics or hospitals out of concern that Immigration and Customs Enforcement (ICE) agents will detain them. Such qualms are justified. Since 2004, ICE has conducted numerous raids in immigrant communities and deporting thousands. In San Diego, ICE agents have been known to monitor Spanish radio stations to learn the location of mobile medical units in migrant neighborhoods (Fernández-Kelly and Searles, this volume).

Clinics serving unauthorized immigrants have adopted various strategies to reduce the well-justified fear of government raids. Mobile units in San Diego have ceased to advertise their routes and location. Good News Clinic in Homestead, Florida situated its facilities next to a Baptist Church which ICE agents are unlikely to violate. Fear of deportation is significantly less in Miami than in other locations because of the large size of the immigrant population.

The second type of fear entails bureaucratic rules and billing. Stories of huge invoices ruining patients and their families lead ill immigrants to postpone hospital visits until their condition becomes urgent. This brings about avoidable complications and sometimes irreparable damage. The director of a community clinic in north San Diego relates the case of a Mexican boy suffering from a brain hemorrhage. His parents took him to a distant clinic – the only place they knew would provide free care – driving past the ERs of several hospitals. By the time the boy arrive at the clinic, it was too late; the boy died on the spot.

Patients have reason to fear bureaucratic rules. “Every patient who arrives here carries a dollar sign in his forehead,” says the director of one of the largest emergency rooms in South Florida, “one way or another, he or she will be billed.” (Field interview, South Florida Health Workers Union Headquarters, 2007).

c. Understanding the Health Care System from the Inside

Such statements contrast with those obtained in interviews with hospital administrators and physicians. Almost invariably, administrators state that their mission is to provide “compassionate health care” and to “serve our community.” Physicians chime in with resolute assertions that they treat everyone the same, “without regard for their ability to pay.” Patients themselves confirm these statements indicating that, once admitted, physicians and nurses treat them well and in ways comparable to paying patients. What then explains their reluctance to seek care?

The reason for the paradox lies in the survival imperatives of hospitals and clinics in the absence of a system of universal free care. In this sense, for-profit institutions are the most explicit, commonly building their facilities in suburban locations away from poor areas. [1] Some non-profits follow the same policy, but even those with a stronger sense of mission complain of being hampered by complex rules for obtaining reimbursement for indigent care. Federal rules require proof of citizenship for Medicare and Medicaid. Even Federally Qualified Health Centers - the closest thing to a national safety net - require proof of residence and income.

At first blush, such requirements appear reasonable, but they lead to unanticipated consequences. Some funding programs require clinics and non-profit hospitals to demand proof of earnings in the form of last year’s income tax return -- a requisite completely out of

reach among unauthorized migrants working in agriculture or in the informal economy. Barring that, they are asked to bring notarized letters from their employers but informal employers are loath to provide such documents and the sole act of asking for such a letter may be grounds for dismissal. Furthermore, proof of income may require documentation about the incomes of other household members. These often include non-relatives living in the same house or apartment who are most unwilling to provide such information. Proof of legal residence may seem easier, but it often entails the presentation of rent receipts or utility bills. For seasonal workers who move from place to place and live four or five to a room, such documentation is hard to come by. As in the case of proof of income, proof of residence assumes a stable residential situation (Hadley and Holahan 2003; Light 2004).

Such rules have the unintended effect of creating a fictitious indigent pool. Patients able to produce income tax returns and utility bills are economically above the truly needy. Neither the homeless nor unauthorized migrants fit into this category. Consequently, they are frequently shunted aside and barred from access to care. Until now, federally qualified health clinics are, forbidden to provide free care to those without proof of residence and income. While patients can still be seen by a physician, they must pay upfront. Fees are modest, but they can accumulate: up to $30 to be seen by a doctor; another $30 for required analysis; $20 for medicines, etc. For many, the total sum becomes prohibitive.

The functioning of the American health system is, in stylized form, summarized in Figure 1. Neither administrators nor direct health providers handle insurance eligibility forms or proofs of residence or income. This task is delegated to clerical personnel whose function is to transform care seekers into “paying patients”, either directly or through a government aid program. The first encounter of a patient seeking help at a hospital or clinic is not with a nurse or physician, but with a clerk. Gate-keeping tends to harden their intake personnel, which is why first encounters can be impersonal and unfriendly. Before the doors of the coveted examination room are opened, front door clerks must be satisfied that the all-important question – who is going to pay for these services? – is answered properly.

The gate-keeping line performs a double function: first, it protects the economic viability of the institution and second, it insulates higher-order personnel from contact with indigent or ineligible care seekers. Denial of access to care in terms reported by several of our informants – “We cannot see you; we seek a different kind of patient here.” or “You need to bring us a certified check for xxx dollars before we can see you,” – are not made by top administrators, much less physicians, but by intake clinical staff. Medical personnel may continue to inhabit a Hippocratic bubble of care to all, “without regard for their ability to pay,” oblivious that patients have been screened precisely on that basis at the front desk. The organization of health care institutions, of course, varies greatly depending on their goals and sense of mission; but the core relationships sketched in Figure 1 represent the normative pattern in for-profit hospitals, as well as in many non-profit institutions.

Systemic Contradictions

The economy continues to source its needs for unskilled labor in poorer countries, particularly Mexico. In the absence of legal channels of entry, workers are pushed underground. The unauthorized population is then excluded from access to most hospitals and clinics or excludes itself because of the barriers and fear described above. As a result, its physical condition deteriorates. Obesity, hypertension, and diabetes are reported by the clinicians to have reached epidemic proportions. Infectious diseases, such as tuberculosis and AIDS also go undetected (Persichino and Ibarra in this issue).

These negative outcomes affect migrants themselves, but then bear on society as a whole. Left untreated, chronic conditions lead to life threatening episodes that land patients in

emergency rooms. The cost of caring for them, even "stabilizing" them – as done in for-profit and non-profit hospitals – is often higher than the cost of primary care, which would have prevented such episodes in the first place. To the millions of dollars that emergency care imposes, must be added risks to the entire community derived from the unchecked spread of infectious diseases within the migrant population. As one of the directors of the Family Health Clinics of San Diego puts it:

> Borders are fluid and we have one of the most porous borders in the world. Many people who work in this clinic live in Tijuana. If immigrants don't get proper and timely health care, their ailments don't stay on one side of the border; everybody is placed at risk. People don't seem to understand that when immigrants are penalized, everyone else is, too.

Coping Strategies

Maintaining and restoring health requires that the needy find alternatives to the dominant institutional order. Immigrants and their advocates are not entirely helpless and, by dint of ingenuity and effort, they have developed several options. These coping mechanisms fall into three categories: informal medicine, organized compassion, and transnational care.

a. Informal Service Providers

The barriers and expenses of formal health care have led to the emergence of an informal medical sector. While such care cannot provide surgical and other major services, it can offer primary assistance, seek to alleviate chronic conditions, and offer a measure of psychological comfort. Folk medicine proliferates in immigrant areas, staffed by healers claiming either supernatural powers or special expertise. African-inspired religious sects such as *Santeria* in Cuba or voodoo in Haiti and the West Indies provide a variety of potions, prayers, and rites to deal with life contingencies, including ill health. Popular pharmacies, known as *botanicas*, furnish herbal concoctions against many ailments, from diabetes and depression to unrequited love (Stepick et al. 2000; Fernandez-Kelly and Konczal 2005). Among Mexican and Central Americans, they are supplemented by other folk beliefs that endow *curanderos*, *sobadores*, and *parteras* with authority. *Curanderos* are general-purpose healers; *sobadores* seek to cure by friction and massage; *parteras* are folk midwives. Folk medicine has a widespread hold over rural migrants in both California and Florida.

A second type of informal health services is provided by unlicensed doctors, dentists, and other health professionals. This kind of "grey medicine" is offered mostly by individuals trained abroad, commonly in the same country as their patients. Having failed to pass accreditation tests required to practice in the United States or not even having attempted to do so, such professionals earn a living by supplying necessary services in immigrant communities. Not only poor workers, but better-off professionals make use of these informal providers. The reason, in addition to their lower costs, is the greater familiarity, comfort, and trust that a common culture can foster. Because the American health system is often regarded as impersonal and bureaucratic, the warmth received from a co-ethnic doctor can compensate for lack of equipment or up-to-date expertise. This type of grey medicine flourishes in areas of high immigrant concentration, especially those characterized by a diversified entrepreneurial base. Chinatowns, "Little Saigons," and "Little Havanas" are places where informal health services commonly thrive (Portes and Stepick 1993).

b. Institutionalized Compassion

Along with the informal medical sector, the most important source of assistance for immigrants, especially the unauthorized, are non-profit hospitals and clinics that operate on a philosophy of health care as a human right. These are mostly, but not always, religiously-

affiliated institutions with a "sense of mission" to assist the poor. Such hospitals cater to paying patients and strive to maintain a healthy bottom line, but they set apart a portion of their resources for charity care in the form of family clinics, "walk-in" clinics, pre-natal and post-natal care, unreimbursed specialized services, and various outreach programs.

Some non-profit hospitals also fall into this category. Hospitals in the Robert Wood Johnson system in New Jersey define themselves as community service institutions and seek to fulfill this mission either through family or walk-in clinics on their premises or through support of other free clinics. Clinics dispense primary or preventive care, but patients requiring special attention are able to see specialists and, when necessary, they are granted hospital admission. Institutional compassion is costly and finance officers in these hospitals must juggle revenue sources to make ends meet.

A chief administrator at Rady's Children's Hospital, a non-denominational, non-profit institution in San Diego catering to a large Mexican immigrant population, describes the challenges faced by her institution as follows:

> Everybody arrives in a catastrophic situation because they do not receive proper medical care on a regular basis and the main reason is fear of detection and deportation…there is out there a new subculture of people who do not receive regular care; a shadow world of people who are in the country but are denied any assistance (Field interview, San Diego, 2008).

Against this grim context, Rady does everything possible to provide access to the unauthorized and the uninsured. It has cultural mediators who ease communication between health providers and patients in various languages, mainly Spanish. The hospital spends between $350,000 and $400,000 every year on translation services and cultural mediation. Recently, the hospital has sought to network with medical institutions in Tijuana, Mexico, that can provide follow-up services to chronic patients ineligible for care in the U.S.

St. Francis Hospital in Trenton, New Jersey displays an extraordinary level of concern and commitment to the needs of the poor, managing to extend services to immigrants, no questions asked about their legal status. The hospital even operates a walk-in clinic in Trenton's "war zone," open to all despite the presence of gangs. Although it faces heavy demand, the hospital maintains relatively stable finances while pursuing a number of in-house and out-reach programs to serve the uninsured.

Federally qualified health clinics (FQHCs) provide another avenue to care. Unlike Medicaid, which is restricted to citizens and long-term legal residents, FQHCs are mandated to "see everyone." Congress, however, requires proof of residence and proof of income, as well as co-payments per visit or procedure. Interviews and direct observation during our study indicate that the extent to which these rules are applied depends on the leadership and sense of mission of the institution. In some cases, the rules are applied strictly; in others, they are bent, as much as possible in favor of indigent patients. At the Family Health Center of San Diego, a fee of $30 is charged upfront, but it is waived when necessary. From its own resources, the Clinic gives away about $100,000 in free care each year, bypassing federal reimbursement channels.

Under President Bush's Health Centers Initiative, the number of FQHCs increased to 1,200 nationwide. Between 2001 and 2006, the number of patients seen at those locations increased by 4.7 million, reaching 15 million in the latter year. (Light 2009; Center for Medicare/Medicaid Services 2008). Each center is governed by a board with a majority elected from users. Despite these strengths, FQHCs experience the problem of how to provide elective specialty care. As one administrator put it, the clinic frequently "hits a wall"

when patients need specialized or surgical treatments they cannot provide. Additional funding under President Obama's health plan will result in further expansion, but coverage is still patchy.

The bottom tier of indigent care consists of free clinics that see everyone without regard for their ability to pay or need for formal documents. Free clinics are often, religiously affiliated and have ties with non-profit hospitals. The Open Door Clinic of Homestead, for example, is associated with the large Baptist hospital in Miami that provides it with a budget, access to prescription drugs and specialist care. Similarly, the St. John Bosco Clinic in Miami is affiliated to and has received assistance from the Catholic Mercy Hospital. In downtown New Brunswick, N.J. the St. John Free Clinic was supported, until recently, by St. Peter's Hospital, which also provides it with access to medical equipment and specialized care.

These clinics are the closest to free and universal care in America. For that reason, they are heavily used by the poor and uninsured. Yet, they are both few in number and small. They are staffed by committed internists and nurse practitioners, and must recruit volunteer specialists to donate a few hours of their time. Clinic administrators in Miami and San Diego complain that their main problem is connecting needy patients with specialists or getting them admitted to a hospital. They must literally "shake the trees" in search of volunteer physicians or young residents. For seriously ill and uninsured patients, this means that access to care is a lottery. They may luck out into a free clinic with good connections to a non-profit hospital; or they may wait for months, while case managers at an FQHC attempt to pry open the doors of a county hospital.

The medical safety net built by private philanthropy and government programs features notable achievements and many examples of extraordinary compassion. Committed physicians and administrators struggle against high odds and unwieldy bureaucracies to care for the underserved and uninsured immigrants. At the same time, the system is opaque, uneven, and inefficient. Federally qualified and free clinics may or may not exist in a given city; mission-driven hospitals may or may not be able to reach the poor, especially those who do not speak English. Even when brought into the safety net, truly ill patients may not make it, given the scarcity of specialist and inpatient care for the poor and uninsured.

c. Medical Transnationalism

A final coping mechanism involves using immigrants' sending countries as a source of medical attention. Several hospitals and clinics in San Diego have responded to the difficulty of finding specialist and follow-up care for migrants by establishing formal and informal partnerships with Mexican institutions. Mexico has a universal, publicly-financed health system. While its quality at high-tech levels may not reach American standards, it is in principle available to everyone (Gomez and Ruiz 2008). The directors of North County Health Services, an FQHC in San Diego, encourage immigrants with legal papers to re-cross the border to gain access to the specialist care that is so hard to obtain on the U.S. side. According to one of our informants:

> Medical care in Tijuana is good. So the patient can request all his paperwork, lab results included, here and find, say, a nephrologist or cardiologist in Tijuana… Identifying more qualified medical personnel in Tijuana would greatly expand our capacity to provide care for patients who fall through the cracks of the American system. (Field interview, San Diego, 2008)

Unauthorized migrants can also get care by returning to Mexico, but they do so only under extreme circumstances because of the difficulty and expense of returning to their jobs in the U.S. More commonly, they send word home when they fall ill, asking for advice from their

kin or local doctors, and requesting that a package of needed drugs or folk remedies be sent to them.

It is a telling paradox that persons in need of assistance residing in the world's most medically advanced country must go back to a less developed country because of the absence or cost of specialist and hospital care in America. Even U.S. institutions are tapping transnational medicine to bypass systemic bottlenecks here. Figure 2 summarizes barriers to health care and immigrant's coping strategies uncovered in the course of this study.

Regional Differences

The situation portrayed in Figure 2 is common to the nation, but it registers regional variations. The research design for our study revealed some telling differences by contrasting scenarios found in South Florida, Southern California, and Central New Jersey. They offer a glimpse of key factors affecting the treatment of the foreign-born patients in the three locations. Because of space limitations, we delineate only the principal contrasts among them.

In Miami-Dade County, a half-penny sales tax for indigent care, approved by the local electorate, provided funds to support an extensive network of charity care centered on the Jackson Memorial Medical Center. Jackson, a county hospital, has created and supports a number of satellite clinics catering to the poor and uninsured. This means that patients requiring surgery or other in-patient treatments can be referred directly. More importantly, these clinics do not require proof of legal status, thus giving access to the unauthorized population.

On the negative side, satellite clinics demand proof of income and proof of county residence. Many unauthorized migrants – and homeless persons - have difficulty coming up with the requisite documentation; if they cannot produce it, they are not seen on a regular basis unless they pay upfront. Some estimates put the proportion of those who cannot access this safety net as close to half of the needy population. A number of FQHCs and community clinics supplement the county system, but they are also hampered by federal requirements. In that context, the only recourse for the very poor are the three or four free clinics in the area.

The Jackson complex centralizes official indigent funds, but the enormous demands placed on it have created a large bureaucratic structure and major delays in inpatient care, even for those referred by its own satellite clinics. Thus, the health care situation in South Florida is mixed. The political power of Cuban-Americans and other Latinos has translated into a system serving the settled migrant population able to document local residence, but not the poorest or most recent arrivals. These are pushed to the edges of the system, depending on private philanthropy or a few compassionate hospital administrators willing to bend the rules.

Conditions in Central New Jersey are better because they reflect a progressive political tradition in that state. Despite growing financial constraints, New Jersey manages to fund a sizable Charity Care program that reimburses hospitals on a sliding scale basis depending on the size of their indigent patient load. In Miami-Dade County, patients are not asked for proof of legal residence. Proofs of state residence and income are required, but they appear to be administered leniently. There is no county hospital in Central New Jersey, but we could not identify a single for-profit hospital. Most non-profit institutions in the state sponsor family or walk-in clinics where the uninsured are seen free of charge. Unauthorized migrants comprise a sizable proportion, sometimes the majority of this population.

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As elsewhere, specialist referrals and in-patient care remain the key bottleneck in New Jersey but, by contrast to the highly bureaucratized Jackson system, access to more expensive forms of care is easier. This is owed, in part, to reimbursement by the state Charity Program and to the number of hospitals in the area with a “sense of mission.” Of the three regions studied, New Jersey appears to offer the best chances of good care for the uninsured and unauthorized, including those suffering from chronic and major illnesses.

San Diego County sits at the opposite end of the spectrum. As one clinic administrator put it, “This is a bad place to get sick if you are poor.” (Field interview, San Diego, 2008). There are numerous for-profit hospitals, including “concierge” institutions catering to the wealthy. The County Board of Supervisors has made it its mission to block the unauthorized population from publicly-funded services. This is peculiar since agriculture and tourism, the two pillars of the San Diego economy, depend heavily on Mexican migrant labor. The County’s network of clinics requires proof of legal residence and income, and automatically excludes most immigrants.

A number of large, well-financed community clinics exist in San Diego - such as the San Ysidro Health Center and North County Health Services - that trace their origins to the Free Clinic movement linked to agricultural unionization campaigns of the 1960s (Fernández-Kelly, this volume). One of those centers even keeps the name of the original popular institution – *Clinicas de Salud del Pueblo*. Most of these are now FQHCs, they are strongly imbued with a sense of mission toward migrant laborers and the dispossessed. As noted previously, the main bottleneck is specialist and in-patient care for serious cases since these clinics have no direct access to any hospital. Some administrators thus take the remarkable step of sending patients across the border for follow-up and specialist care. As a nurse at St.Vincent de Paul Clinic reported: “In an emergency, we call an ambulance, and it’s up to the driver to decide where to take the patient.” From a health standpoint, it thus makes a great deal of difference where migrants settle.

Conclusion

The regional contrasts, however, represent variations around a common theme. Both the American immigration and health systems can be characterized as "broken"; the first because of its failure to address the labor demands of the economy in a legal, normal basis; the second because of the perennial conflict between different definitions of health care and the power of interests vested on a profitable care system. The outcome is an unpredictable and inefficient institutional structure.

Reform of the two systems whose clash has been described in this article rests on different principles. The emphasis of immigration reform should be on the *economic* importance of cross-border labor flows and the need to manage them on a predictable, fair, and legal way. By contrast, the emphasis of health care reform should be on the *non-economic* character of the services provided, removing them from the sway of the market and restoring them to their natural function as a public service, dispensed on a universalistic basis.

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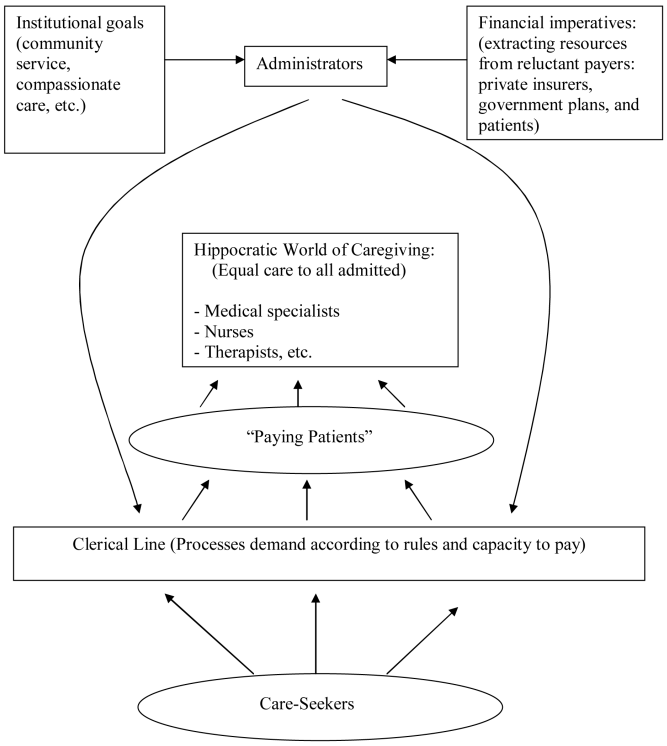

Figure 1.
The American Health System

Barriers	*Consequences*	*Coping Strategies*
Lack of English; foreign cultural definitions of illness and care	Difficulties in describing symptoms; misunderstandings in communication; inability to follow prescribed treatments	Co-ethnic formal and informal medical providers
Lack of insurance	Inability to access inpatient and specialist care; high costs of prescriptions	Folk healers and medicines; unlicensed doctors and dentists
Recency of Arrival (for legal immigrants)	Temporary ineligibility for Medicaid, Medicare, and other federal health programs	Community (FQHCs) and free clinics; transnational medicine (regular or occasional trips home)
Unauthorized Status	Permanent ineligibility for Medicaid and other federal programs; fear of detection and deportation when seeking care	Folk healers and other informal providers; free clinics; transnational medicine (drugs and folk remedies sent from home; return in emergencies)

Figure 2.
Immigrants and the American Health System

Table 1

Characteristics of Human Capital Immigrants, Manual Labor Immigrants, and Political Refugees to the U.S., ca. 2000

	Professional Migrants		*Manual Labor Migrants*			*Political Refugees*	
	Chinese	**Filipinos**	**Haitians**	**Mexicans**	**Nicaraguans**	**Cubans**	**Vietnamese**
Less than high school, %[1]	4.4	12.0	35.5	69.8	39.6	39.3	30.8
College graduates, %[1]	64.3	44.8	12.6	3.7	14.1	20.9	7.6
Mean annual incomes, $[2]	58,267	49,007	16,394	22,242	32,376	48,266	26,822
Professional-executive occupations, %[3]	47.9	28.5	9.3	5.1	7.2	23.3	12.9
Intact families, %[4]	76.7	79.4	44.9	59.5	62.8	58.8	73.5

[1] Person 16 years of age or older, 2001.

[2] Family incomes in 1996 dollars.

[3] Person age 25-64.

[4] Both biological or adoptive parents present.

Source: Adapted from Portes and Rumbaut, 2006, Table 39.

Table 2

Well-being Index among Legal Immigrants, 2003

	Illness/SeriousMedical Conditions Reported for Prior Year:					
	Zero %	**One %**	**Two %**	**Three or more %**	**Mean**	**N[1]**
Total Sample	94.90	1.92	0.98	2.2	0.16	8,573
Sex:						
Males					0.10	4,133
Females					0.21	4,440
Age:						
<23					0.00	703
24-33					0.00	2,856
34-48					0.08	3,116
49-63					0.40	1,259
>64					1.33	599
Nationality:						
China					0.12	440
El Salvador					0.10	486
Ethiopia					0.05	197
India					0.12	745
Mexico					0.29	1,158
Philippines					0.15	504
Poland					0.01	194
Vietnam					0.11	211
All others					0.15	4,599

[1] Missing cases coded to 0.

Source: New Immigrant Survey.

Table 3

Hospitalization Rates among Legal Immigrants, 2003

	Hospitalization Last Year		
	No %	Yes %	N[1]
Total Sample	94.17	5.83	8,251
Sex:			
Males	91.54	8.46	4,253
Females	96.97	3.03	3,998
Age:			
<23	94.25	5.75	696
24-33	92.71	7.29	2,799
34-48	95.29	4.71	3,016
49-63	96.00	4.00	1,149
>64	91.12	8.88	552
Nationality:			
China	96.25	3.75	427
El Salvador	94.18	5.82	481
Ethiopia	97.46	2.54	197
India	95.86	4.14	724
Mexico	91.74	8.26	1,078
Philippines	92.49	7.51	493
Poland	92.18	7.82	179
Vietnam	96.65	3.35	209
All others	94.26	5.74	4,424

[1] Missing data excluded.

Source: New Immigrant Survey.